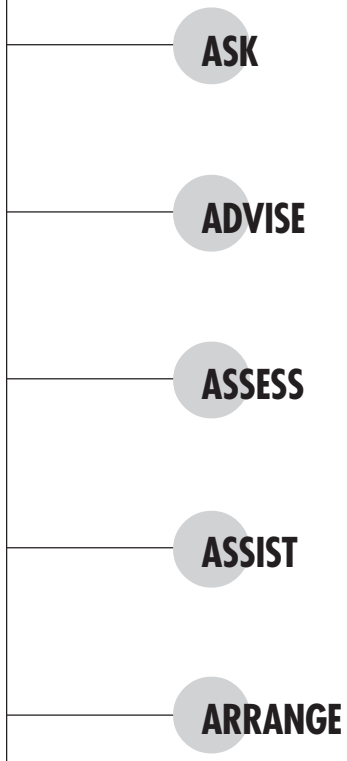
Substance Abuse During Pregnancy: Guidelines for Screening

Revised Edition 2002



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Revised Edition 2002

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Adapted from *Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health*, published by the National Center for Education in Maternal and Child Health, 1997.

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Preface

Substance abuse during pregnancy has been identified as an issue critical to the health of mothers and babies from all socioeconomic groups. We estimate that in Washington state, between 8,000 and 10,000 infants born each year are exposed to drugs and alcohol. Of these infants, between 800 and 1,000 are drug or alcohol affected. Since there are no defined safe limits during pregnancy, any use should be avoided. Substance abuse contributes to obstetric and pediatric complications, including Fetal Alcohol Syndrome (FAS), prematurity and abruptio placenta.

Treatment for substance abuse during pregnancy can be more effective than at other times in a woman's life. Providers play an important role influencing the health behaviors of the pregnant women in their care. Pregnant women often describe their health care providers as the best source of information and generally follow their advice. We know that FAS and the deleterious effects of drugs are preventable. If we are successful in preventing these adverse effects, substantial cost savings may be realized, including health care, foster care, special education and incarceration.

In spring of 1998, HB 3103 was passed and signed into law by Governor Gary Locke. As a result, the Department of Health was directed to develop screening criteria for identifying pregnant and lactating women at risk of producing a drug-affected baby. The screening criteria were developed as guidelines based upon input from key informant surveys, and the HB 3103 Advisory Workgroup. They include material from the 1997

publication *Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health*, published by the National Center for Education in Maternal and Child Health.

I want to thank all those who assisted in the development of these guidelines. Reduction of perinatal chemical dependency and its devastating effects can be achieved through improved identification of drug use prior to or early in pregnancy, and utilization of consistent evidence-based medical protocols. Early identification is the first step toward engaging chemically dependent women into treatment. Primary prevention efforts in family planning and primary care setting aimed at identification prior to pregnancy are also of critical importance in achieving a significant reduction in perinatal drug use. We hope this booklet will help all health care professionals working with pregnant women enhance their skills and improve care for women and infants.

Maxine Hayes, MD, MPH
Health Officer
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Purpose

The American College of Obstetrics and Gynecology (ACOG) 1994 *Technical Bulletin Number 195 on Substance Abuse in Pregnancy* recommends that all pregnant women be questioned thoroughly about substance abuse. The purpose of this booklet is to:

- Improve provider ability to effectively screen and identify pregnant women with substance use/abuse issues
- Provide guidelines for screening and follow-up
- Provide sample screening tools
- Provide recommendations related to drug testing of pregnant women and newborns
- Provide referral resource numbers

Definitions

Use refers to any use of alcohol or drugs.

Abuse is a recurring pattern of alcohol or other drug use which substantially impairs a person's functioning in one or more important life areas such as familial, vocational/employment, psychological, legal, social or physical.

Dependency is dependent use which is a primary chronic disease with genetic, psychological and environmental factors influencing its development and manifestations including physical/physiological dependence as evidenced by withdrawal. Psychological dependence is evidenced by a subjective need for a specific psychoactive substance such as alcohol or a drug. Women who abuse substances or are chemically dependent require different interventions than men.

Addiction or Addictive Process: A complex, progressive behavior pattern having biological, psychological, sociological and behavioral components. The addicted individual has pathological involvement in or attachment to a behavior (substance use); is subject to a compulsion to continue to use and has reduced ability to exert personal control over the use.

Screening: Methods used to identify risk of substance abuse during pregnancy and postpartum, including self report, interview and observation. All pregnant women should be screened, ideally at every encounter, for substance use, abuse and dependency. Rescreening should be done if risk factors are present or if the woman has a history of alcohol or drug use.

Testing: Process of laboratory testing to determine the presence or absence of a substance in a specimen. Universal testing may be used as a screening tool in some practices, but is not recommended (see pages 5 and 13-16).

Assessment: Comprehensive evaluation of a client's risk for substance abuse during pregnancy and postpartum. The following are characteristics of assessment:

- Includes collecting objective and subjective information
- May include screening and lab testing
- Should be timely and culturally appropriate
- May result in a diagnosis and plan for intervention
- Specialized assessments such as chemical dependency assessments may be part of an initial assessment or may follow screening.

Scope of the Problem

In 1996, a Department of Health & Human Services survey measured substance use among women in the United States. Although accurate data is difficult to obtain on this topic, the survey estimated that 5.5% of women in the United States used illicit drugs, 18.8% drank alcohol, 20.4% smoked cigarettes, and 5–10% of all women used some type of substance during pregnancy.

In Washington state, it is difficult to estimate the number of alcohol/drug exposed and affected infants. Accurate, population-based, available data sources are limited and often combine episodic use of alcohol and drugs with chronic addiction.

Washington state data combines episodic use and chronic addictive patterns to reveal that 8,000–10,000 infants are born each year exposed to alcohol or drugs. Exposure means any exposure to a potentially harmful substance including tobacco. Of the infants exposed, 800–1000 are alcohol or drug affected. This means that the infants are diagnosed at or after birth as having signs/symptoms and other measurable effects due to drug/alcohol use by their mothers.*

PRAMS (Pregnancy Risk Assessment Monitoring System) population-based survey data provide more information about alcohol and tobacco. In 1999, 12.1% of mothers in Washington state smoked tobacco in the third trimester. Highest rates occurred in low-income women (Medicaid rate 19.7%). Alcohol use was higher

* Figures are estimates using existing data from DSHS: Research and Data Analysis, 1997.

among non-Medicaid mothers than those on Medicaid, however. In 1999, 7.1% non-Medicaid mothers, compared to 4.0% Medicaid mothers, used alcohol in the last three months of pregnancy.

The Role of the Health Care Provider

It is the responsibility of every practice to make sure that all pregnant and postpartum women are screened for substance use. Physicians, nurses, and others involved in prenatal care play an important role in the reduction of substance use during pregnancy. For clients who require intervention for substance use, a team approach is required from the primary provider, clinic nurse, social worker, public health nurse, chemical dependency treatment provider, and the client herself.

In order for the health care team to screen clients effectively, members of the team must be educated about when and how to screen, how to assist the woman who admits use, and about associated issues in the substance using/abusing woman's prenatal and postpartum care.

Benefits of Universal Screening

Universal screening provides the practitioner with the opportunity to talk to every client about the risks of alcohol, illicit drugs, prescription drugs, tobacco, and other substances and risky behaviors. Structured screening, built into the care of every pregnant woman, helps eliminate "educated guessing", which is heavily dependent on practitioner bias and attitudes. With education and practice, the provider's skill and comfort with confronting these issues improves, interviewer bias is eliminated, and the stigma of substance use and abuse is reduced. The practice of universal screening increases the likelihood of identifying substance users and allows for the earliest possible intervention or referral to specialized treatment.

Screening is conducted by interview, self-report, and clinical observation. Screening takes only about 30 seconds for most patients who do not have a substance use problem and 5–10 minutes for the 10–15% of patients who do. This small investment actually saves time by answering questions that might come up later, and by reducing care time for a patient in whom obstetrical complications can be prevented through early identification of this risk factor. In addition, screening and education of every client enhances public awareness of the risks of substance use/abuse during pregnancy and may prevent use/abuse in future pregnancies.

Urine Toxicology Not for Universal Screening

Urine toxicology may be useful to follow up a positive interview screen. For more information about the benefits and limitations of urine toxicology, see pages 13-16.

The ACOG 1994 Technical Bulletin concluded that urine testing has limited ability to detect substance abuse and therefore does not recommend universal urine toxicologies on pregnant women as a screening method.

Screening Tools

Interview-based or self-administered screening tools are the most effective way to determine risk and/or allow self reporting. Brief questionnaires have demonstrated effectiveness for assessing alcohol and drug use during pregnancy. Examples of tools that have been validated for this population and take 5–10 minutes or less include the T-ACE, TWEAK, CAGE, and 4 P's (see Appendix A, pages 23–33).

Use a screening tool with every client, not just those in whom substance use is suspected. Women should be screened for alcohol, illicit drugs, tobacco, misuse of prescription drugs and other substances, including use prior to pregnancy. If the screening tool focuses on alcohol (for example, the T-ACE) another tool should be administered to screen for additional substances. For an example of a tool that covers both alcohol and drugs, see page 25.

ASK

How to Screen

Screening is a skill, and staff should be trained in interview techniques. The screening should be performed by the health care provider or other staff member who has an ongoing relationship with the client, and results of the screen should be discussed with the client and documented in the chart. If the client is screened by someone other than the primary obstetric provider, the provider should review the results of the screen and give appropriate follow-up messages to the client.

Make substance screening a routine part of prenatal care services. This approach decreases subjectivity, discomfort and bias. Ideally, pregnant women should be screened at each encounter, and minimally, once each trimester. Include inquiries into substance abuse problems in family members. Know how to respond to both positive and negative responses to screening tools (see page 9). As trust develops, the client who is using is more likely to disclose that use. When use is disclosed, remember that screening tools identify risk but are not diagnostic. Know how to respond, including discussing risks of use, benefits of stopping, and resources for further evaluation (see page 9 and Appendix B, page 36).

Recent addiction research has identified physical, sexual, and emotional abuse as frequent precursors to substance use in women; therefore, pregnant women should also be screened for risk of domestic violence. In addition to brief structured screening tools, asking about foster care during childhood, or history of foster care for the woman's own children may lead to discussion of the potential for substance use.

Create a Respectful Environment

Supportive inquiry about use of drugs or alcohol can open the door to referral and treatment. In order to elicit an honest response, a safe and respectful environment is essential.

- Assume that all women want a healthy baby. However, do not assume that all women know when they became pregnant or welcome the current pregnancy.
- Educate support staff about the importance of a positive and nonjudgmental attitude in establishing a trusting relationship and welcoming environment.

- Observe and protect provider/client confidentiality. For example, know the issues surrounding consent for testing clients and newborns (see page 16).
- Ask every question in a health context. This lessens the stigma associated with the topic, and expresses concern for the health of the mother and baby.
- Be empathetic, nonjudgmental and supportive when asking about use; consider the client's needs and life situation.
- Offer culturally appropriate screening in the client's primary language.

ADVISE

Educational Messages for Clients

Assume that all women have some knowledge of the effects of drugs, alcohol, and cigarettes on pregnancy. Ask what the woman knows, then fill in the missing pieces and clarify misconceptions. This is an excellent opportunity to educate the client and her partner about the adverse effects of tobacco, drugs, and alcohol, and the benefits of stopping use at any time during pregnancy or postpartum. These messages can be reinforced through pre-pregnancy, pregnancy, and postpartum discussions not only by the primary obstetric provider, but by the community childbirth educator, outreach worker, community health nurse, and other health care staff.

ASSESS

When a Woman Denies Use

Many women do abstain from drugs and alcohol, especially during pregnancy. Acknowledge this wise choice and review the benefits of abstinence from substances. Continue to screen throughout pregnancy and postpartum, ideally at each encounter, but at least once per trimester. In some situations, women may deny use but a constellation of signs and symptoms suggest abuse. In this case it may be prudent to re-screen frequently or conduct lab testing (see page 14).

When a Woman Admits Use

Many women are able to abstain during pregnancy, so the woman who admits to current use of significant amounts is likely to have remarkable addiction and may be using substances to help her cope with psychosocial stressors in her life. The woman may feel safe enough to share with the medical provider about her use but may not be ready to take the next step of a comprehensive assessment and treatment.

The **Stages of Change** model developed by Prochaska and DiClemente (1992) is one approach to understanding the steps to changing drug or alcohol use during pregnancy.

Stages of Change

The stages of change are:

1. Pre-contemplation
2. Contemplation
3. Preparation
4. Action
5. Relapse

Pre-contemplation. The woman is not considering change during the pre-contemplation stage.

- She may not believe it is necessary (examples: used during last pregnancy and nothing happened, or her mother used while pregnant with her and she is okay).
- She may not know or understand the risks involved.
- She has tried many times to quit without success, so has given up and doesn't want to try again.
- She has gone through withdrawal before and is fearful of the process or effects on her body.
- She feels strongly that no one is going to tell her what to do with her body.
- She has mental illness or developmental delay and does not have a good grasp of what using drugs and alcohol during pregnancy means—even when information is given to her.
- She has family members or a partner, whom she depends on, who use. She may not contemplate changing when everyone else continues to use.

The woman in pre-contemplation may present as resistant, reluctant, resigned, or rationalizing.

Resistant: *"Don't tell me what to do."*
Provider Response: Work with the resistance. Avoid confrontation by giving facts about what it will do to her and her fetus. Ask what she knows about the effects; ask permission to share what you know, and then ask her opinion of the information. This often leads to a reduced level of resistance and allows for a more open dialogue.

Reluctant: *"I don't want to change; there are reasons."*
Provider Response: Empathize with the real or possible results of changing (for example, her partner may leave).

It is possible to give strong medical advice to change and still be empathetic to possible negative outcomes to changing. Guide her problem solving.

Resigned: *"I can't change; I've tried."*
Provider Response: Instill hope, explore barriers to change.

Rationalizing: *"I don't use that much."*
Provider Response: Decrease discussion. Listen, rather than responding to the rationalization. Respond to her by empathizing and reframing her comments to address the conflict of wanting a healthy baby and not knowing whether "using" is really causing harm.

Contemplation. The woman is ambivalent about changing her behavior. She can think of the positive reasons to change but also is very aware of the negative sides of change (see above).

Provider Response: Health care providers can share information on the health benefits of changing for the woman and fetus. The woman in contemplation will hear these benefits, but is very aware of the negative aspects of change on her life. Help the woman explore goals for a healthy pregnancy, and problem solve how to deal with the negative aspects of abstinence.

Preparation. The woman's ambivalence is shifting toward changing her behavior. She is exploring options to assist her process. She may be experimenting by cutting down, or has been able to quit for one or more days. Although her ambivalence is lessening, it is still present and may increase when she is challenged by

those around her, triggered by the environment, or is under other types of stress she has handled by using in the past.

Provider Response: Acknowledge strengths; anticipate problems and pitfalls to changing, and assist the woman in generating her own plan for obtaining abstinence. Problem solve with her regarding barriers to success.

Action. The woman has stopped using drugs and/or alcohol.

Provider Response: Acknowledge her success and how she is helping her infant and herself; have her share how she has succeeded and how she is coping with the challenges of not using. Offer to be available for assistance if she feels that she wants to use drugs/alcohol again.

Relapse. The woman may relapse; incidence of relapse for those who are abusing or addicted is high.

Provider Response: Discuss triggers, stressors, social pressures that may lead to relapse and help the woman plan for them. At future visits, if the relapse has occurred, guide the woman toward identifying what steps she used to quit before. Offer hope and encouragement, allow the woman to explore the negative side of quitting and what she can do to deal with those issues. (How did she deal with those issues in the past? Explore what worked and didn't work for her.) Offer to provide assistance in finding resources to help her return to abstinence.

Laboratory Testing

Urine toxicology determines the presence or absence of a drug in a urine specimen. It may be useful as a follow up to a positive interview screen.

Benefits of Lab Testing

- Confirms the presence of a drug
- Determines the use of multiple drugs
- Determines if a newborn is at risk for withdrawal

Limitations of Lab Testing

- Negative results do not rule out substance use.
- A positive test does not tell how much of a drug is used.
- A positive test does not identify user characteristics such as intermittent use, chronic use, or addiction.
- Alcohol, which is the most widely abused substance and has the greatest impact on the fetus, is the hardest to detect due to its short half-life.
- A woman who knows she will be tested may delay access to prenatal care because of fear of potential repercussions.
- False positive results can be devastating for a drug-free client.
- Urine toxicology has no value in identifying or minimizing the teratogenic effects that occur early in pregnancy.
- **Blood tests** usually only identify those patients with long term use in whom secondary symptoms have occurred, e.g., liver function tests.
- Women may avoid detection by abstaining for 1-3 days prior to testing, substituting urine samples, or increasing oral beverage intake just before the testing to dilute the urine.

Indicators for Testing

Some risk indicators are more indicative of substance use than others. If positive risk indicators are identified at any time during pregnancy or postpartum, rule out other identifiable causes, re-screen, test, or provide assessment as appropriate. (See also Signs and Symptoms of Substance Abuse on page 15.)

High Risk Factors

- Little or no prenatal care
- Inappropriate behavior (e.g., disorientation, somnolence, loose associations, unfocused anger)
- Physical signs of substance abuse or withdrawal
- Smell of alcohol and/or chemicals
- Recent history of substance abuse or treatment

Risk Factors Requiring Further Assessment Before Urine Toxicology Testing

- History of physical abuse or neglect
- Intimate partner violence
- Mental illness
- Previous child with FAS or alcohol related birth defects
- Fetal distress
- Placenta Abruptio
- Preterm labor
- Intrauterine Growth Restriction (IUGR)

Signs and Symptoms of Substance Abuse

Because of the frequency of complications seen in substance abusers, it is important that the clinician be alert for clinical and historical cues that may indicate the possibility of substance abuse. Based on clinical observation, laboratory testing for substance abuse may be indicated in order to provide information for the health care of the mother and newborn.

Behavior Patterns

Sedation
Inebriation
Euphoria
Agitation
Disorientation
Prescription drug seeking behavior
Suicidal ideations/attempt

Physical Signs

Dilated or constricted pupils
Tremors
Track marks or abscesses/injection sites
Inflamed/eroded nasal mucosa
Increased pulse and blood pressure
Hallucinations
Nystagmus

Laboratory

MCV over 95
Elevated MCH, GGT, SGOT, Bilirubin, Triglycerides
Anemia
Positive urine toxicology for drugs

Medical History

Frequent hospitalizations
Gunshot/knife wound
Unusual infections (cellulitis, endocarditis, atypical pneumonias, HIV)
Cirrhosis
Hepatitis
Pancreatitis
Diabetes
Frequent falls, unexplained bruises
Chronic mental illness

Compiled from ACOG Technical Bulletin #194 (July 1994) and American Society of Addiction Medicine (301-656-3920 or www.asam.org)

Consent Issues for Testing

No uniform policy or state law exists regarding consent for newborn drug testing. This is a complex issue and care providers may wish to seek legal consultation regarding regional practice standards. Most hospitals rely on the newborn general consent for care. Controversies still exist regarding the extent to which maternal consent is required prior to toxicology testing of either the mother or the baby. One opinion holds that the signed general consent for care covers all tests necessary for medical diagnosis or treatment. Another holds that a specific and informed consent must be obtained from the mother for newborn testing. This consent would highlight the fact that a positive result may be reported to Child Protective Services (CPS) and may be used for legal action against the mother. Currently, no Washington state law declares drug use during pregnancy to be a criminal act.

Therefore, the intent of the testing may determine the type of consent. Women with admitted histories of drug use, or women and infants exhibiting signs of drug exposure can be tested under the general consent because results of the test influence medical care and follow up. However, if the total or partial intent of the testing is to bring legal action against the woman, a consent containing specific language defining possible consequences is advisable.

The importance of clear and honest communication with the woman regarding drug testing cannot be overstated. The health care team should act as advocate for mother and infant. This relationship is more difficult to establish if a woman is notified of testing after the fact. Therefore, all women should be told of planned medical testing. The rationale for testing should be documented in the medical record. If a patient refuses testing, this should be documented and testing not performed.

ASSIST/ARRANGE

Referral to Treatment

Discuss the benefits of treatment and offer to provide the woman with a referral to a local chemical dependency treatment center. If the woman is unwilling to make that commitment, ask if she would like some information to take with her if she should change her mind. Schedule the next prenatal visits, continue to maintain interest in her progress and support her efforts in changing. Monitor and follow up on any co-existing psychiatric conditions.

- Know your resources: maintain a current list of local resources (see Appendix C, page 39, for statewide resources). If possible, make the appointment while the patient is in the office.
- Discuss the possible strategies for her to stop; for example, individual counseling, 12-step programs, and other treatment programs. Studies have shown that people given choices are more successful in treatment.
- Become familiar with the Treatment Access Matrix (see Appendix B, page 36).
- Utilize an advocate or special outreach services if available—CPEP, PCAP, MSS—(see Appendix C, page 39).
- Tailor resources according to client needs and health insurance coverage.

- Know the resources in your area, or find out by calling the Alcohol/Drug 24-hour Help Line at 1-800-562-1240. Resources may include:
  - Maternity Support Services and Maternity Case Management
  - County substance abuse services
  - Twelve-step programs
  - Hospital treatment programs
  - Mental health programs
  - Special pregnancy related programs
- If immediate chemical dependency treatment or other support is not available, the primary provider or designated staff might meet with the woman weekly or biweekly to express concern and to acknowledge the seriousness of the situation.
- Maintain communication with the chemical dependency treatment provider to monitor progress.
- Establish rules and goals, such as reducing use, with the woman and her significant others. See the section on Harm Reduction.
- For tobacco users, provide the ACOG brief intervention (see pages 34–35) and refer women to the state Quit Line (see page 44).
- If the behavioral approach is not successful, consider pharmocotherapies: Zyban and/or Nicotine Replacement Therapy, if appropriate for heavy smokers.

Harm Reduction

Praise any reduction in use. Though drug/alcohol abstinence is the goal, any steps made toward reducing use and/or harmful consequences related to use are very important.

When abstinence is not possible, harm reduction assists a woman to take steps to reduce use and harm to herself and her fetus.

Harm Reduction Strategies

- Evaluate and refer for underlying problems.
- Encourage the woman to keep track of substance use.
- Decrease use:
  - Reduce dosage and frequency of use.
  - Recommend reducing her use by one-half each day; if this is not possible, any decrease in use is beneficial.
  - Intersperse use with periods of abstinence.
  - Use a safer route of drug administration.
  - Find a substitute for the substance.
- Avoid drug using friends.

Pregnancy Management Issues

A woman who uses substances during pregnancy is at risk for a variety of complications. The following interventions should be considered in the course of her care.

Prenatal

- Obtain routine blood tests plus hepatitis and tuberculin test and HIV if not included in routine protocol.
- Refer to methadone maintenance program for opiate addiction or medical detox if applicable.
- Schedule more frequent visits to identify medical and psychosocial problems early.
- Conduct random urine toxicologies to monitor use and/or how well the woman is doing with treatment. Expect an occasional positive urine tox and use this as an opportunity to talk about her progress.
- Order and repeat appropriate tests as needed.
- Monitor pregnancy and fetal development.
- Discuss contraceptive methods and make a plan.
- Obtain consent for tubal ligation after delivery if the woman chooses this method.
- Discuss breastfeeding and alcohol/drug use issues.

Intrapartum

- Perform complete history and physical, including recent drug use.
- Repeat hepatitis screen, serologic test for syphilis, and HIV.
- Repeat urine toxicology.
- Alert pediatric and nursing staff.
- Alert social services if necessary.
- Manage pain as appropriate, taking the woman's substance abuse history under consideration.

- Determine method of delivery depending on obstetrical indicators.

Postpartum

- Encourage continuation in a therapeutic drug program.
- Encourage and provide appropriate contraceptive method: Depo-Provera, IUD, ECP (Emergency Contraceptive Pills), condoms, others.
- Support breastfeeding as appropriate. Breastfeeding is not contraindicated in methadone maintenance, depending on the dose, but is contraindicated if the woman is HIV positive.
- Breastfeeding women with a positive history of drug abuse during pregnancy should be tested periodically while breastfeeding.

Associated Issues for Pregnant Women

Pregnant women who need treatment for substance abuse often have different issues than men and non-pregnant women. Pregnancy further complicates treatment needs. Issues of pregnant women may include:

Psychosocial Issues

- Family history of substance abuse
- Physical and/or sexual abuse as a child
- History of sexual assault
- Domestic violence
- Partner with substance abuse issues
- Cultural barriers to care
- Unresolved childhood parenting issues such as substance use, incarceration, and dysfunctional family relationships

Medical Issues

- Sexually Transmitted Infections (STI)
- HIV
- Poor nutrition
- Psychological disorders such as PTSD (post traumatic stress disorder), depression, anxiety, panic, personality disorder, eating disorders, chronic severe mental illness
- Other medical problems such as hepatitis, liver disease, and pancreatitis
- Tobacco use
- Dental disease
- Unintended pregnancy
- Breastfeeding challenges and barriers

Potential Referrals

- Childbirth preparation class
- Transportation to services
- Public assistance/medical assistance/food stamps
- WIC Nutrition Program
- First Steps Services, including Maternity Support Services
- Child care (day care, foster care)
- Peer directed prenatal and postpartum support groups
- Parent skill-building services
- Home management skill-building services
- Education and career building support
- Safe and sober housing access
- Legal services
- Child Protective Services
- Adoption counseling
- Pediatric follow-up for special care infant
- Mental health services
- Domestic violence counseling and services

Appendix A: Screening Tools for Drugs and Alcohol

CAGE

American Society of Addiction Medicine. Questions to Ask Patient pocket card, 2001. (www.asam.org/publ/CAGE.htm)

Questions to Ask Patient

1. Have you ever felt you should Cut down on your drinking or drug use?

2. Have people Annoyed you by criticizing or complaining about your drinking or drug use?

3. Have you ever felt bad or Guilty about your drinking or drug use?

4. Have you ever had a drink or drug in the morning (Eye Opener) to steady your nerves or to get rid of a hangover?

5. Do you use any drugs other than those prescribed by a physician?

6. Has a physician ever told you to cut down or quit use of alcohol or drugs?

7. Has your drinking/drug use caused family problems?

8. When drinking/using drugs have you ever had a memory loss (blackout)?

4 P's

Ewing H, Born Free Project, Martinez, California

This screening device is often used as a way to begin discussion about drug or alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment.

1. Have you ever used drugs or alcohol during this **P**regnancy?
   A) Yes
   B) No

2. Have you had a problem with drugs or alcohol in the **P**ast?
   A) Yes
   B) No

3. Does your **P**artner have a problem with drugs or alcohol?
   A) Yes
   B) No

4. Do you consider one of your **P**arents to be an addict or alcoholic?
   A) Yes
   B) No

Screening Tool for Drugs and Alcohol

This tool was developed by health care professionals and DSHS staff as part of a special demonstration project called First Steps Plus in Yakima, Washington. The tool was found to be effective in identifying women in need of treatment.

First Steps Plus Screen

I. If client is *known to be using* alcohol or other drugs, check boxes in Section I *only* and go on to Section IV.

	Alcohol	Other drug
Self Identification	☐	☐
Positive Medical Finding	☐	☐
Court-Related History	☐	☐
Other (please identify)	☐	☐

II. If client is *not known to be using* alcohol or other drugs, please ask the following questions (4 Ps). Check the boxes

Yes	No	
☐	☐	1. Has either one of your parents had a problem with alcohol or drugs?
☐	☐	2. Does your partner have a problem with alcohol or drugs?
☐	☐	3. Have you had a problem with alcohol or drugs in the past?
☐	☐	4. Have you used any drugs or alcohol during this pregnancy? (Mark yes, even if not *currently using*, as deserves follow-up.)

If client answers YES to either question 3 or 4, then follow up with CAGE questions (5 through 8) and check the boxes.

☐ ☐ 5. Have you ever felt (do you feel) the need to cut down the amount you drink or use drugs?

☐ ☐ 6. Have you ever been (do you get) annoyed or angry because someone criticized your drinking or drug use?

☐ ☐ 7. Have you ever felt (do you feel) guilty about your drinking or drug use?

☐ ☐ 8. Have you ever had a (do you ever) drink or use drugs first thing in the morning to steady your nerves or to get you going (an eye-opener)?

III. Any YES answer to questions 2-8 indicates use or significant risk of use. You may decide risk exists, regardless of screening responses. Do responses indicate:

☐ Use ☐ Risk of Use ☐ No Risk (3-8 negative and no other indicator of risk)

If use, or risk of use, what?

☐ Alcohol ☐ Other drugs ☐ Both ☐ Don't know

IV. If use or risk of use determined, what is your plan for the client?

☐ Case Management ☐ Plus Outreach

Screening Tools for Alcohol Use

Maternal drinking during pregnancy can adversely affect the fetus with effects ranging from mild cognitive impairment and impaired mental functioning to Fetal Alcohol Syndrome, characterized by growth deficiency, central nervous system disorders, and a pattern of distinct facial features. There is currently no known "safe" level of alcohol exposure to the fetus, and maternal ingestion of even small amounts of alcohol carries potential risk to the fetus.

Because there is no safe limit of alcohol consumption during pregnancy, and all women have the potential of drinking some alcohol, health care providers should screen **all** women for alcohol use during pregnancy. Women who drink any alcohol should be encouraged to abstain. Women who are problem drinkers should be supported in changing their behavior through harm reduction, support groups and treatment. Problem drinking and binging can be determined through screening. Screening tools that focus on the amount a woman can drink at one sitting without feeling "high" can uncover tolerance if her intake is greater than 2-3 drinks per sitting. Tolerance suggests that a woman may be addicted or habituated to the use of alcohol and it may be difficult for her to change behavior. More than 5 drinks per sitting is binge drinking and puts the fetus at the highest risk of having an alcohol related birth defect.

Audit

Sanders JB, et al. 1993. Development of the Alcohol Use Disorders Identification Test (Audit) *Addiction* 88(6)

1. How often do you have a drink containing alcohol?
   (0) Never
   (1) Monthly
   (2) 2-4 times a month
   (3) 2-3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1-2
   (1) 3-4
   (2) 5-6
   (3) 7-9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

4. How often during the last year have you found that you were unable to stop drinking once you started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you felt guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (2) Yes, but not in the past year
   (4) Yes, during the last year

10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?
   (0) No
   (2) Yes, but not in the past year
   (4) Yes, during the last year

Scores

Total the numbers of all the circled answers.
A score of 8 or more is considered a positive screen.

T-ACE

Sockol RJ, et al. 1989. The T-ACE questions: Practical prenatal detection of risk drinking: *AM Journal of Obstetrics and Gynecology* 160(4)

1. How many drinks does it take for you to feel high? (**T**olerance)

2. Have people **A**nnoyed you by criticizing your drinking?
   A) Yes
   B) No

3. Have you ever felt you ought to **C**ut down on your drinking?
   A) Yes
   B) No

4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**E**ye-opener)
   A) Yes
   B) No

Scores

Any woman who answers more than two drinks on question 1 is scored 2 points. Each yes to the additional 3 questions scores 1. A score of 2 or more is considered a positive screen, and the woman should be referred to a specialist for further assessment.

Note: A woman could drink 2 drinks per day during pregnancy (safe level is undetermined) and not get a positive screen using this tool. She may not be at risk for alcoholism, but because of her pregnancy she's drinking at an unsafe level.

TWEAK

Russell M. 1994. New assessment tools for risk drinking during pregnancy. *Alcohol Health & Research World* 18(1)

1. How many drinks does it take for you to feel high?

2. Does your partner (or do your parents) ever worry or complain about your drinking?
   A) Yes
   B) No

3. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye-opener)
   A) Yes
   B) No

4. Have you ever awakened the morning after some drinking the night before and found that you could not remember part of the evening before?
   A) Yes
   B) No

5. Have you ever felt that you ought to cut down on your drinking?
   A) Yes
   B) No

Scores

A woman receives 2 points on question 1 if she reports that she can hold more than 5 drinks without falling asleep or passing out.

A positive response to question 2 scores 2 points, and a positive response to each of the last 3 questions scores 1 point each.

A total score of 2 or more indicates that the woman is a risk drinker and requires further assessment.

Note: Drinking at any level during pregnancy is unsafe, even if the woman scores negative with this tool.

Smoking Cessation Intervention for Pregnant Patients

ASK — 1 minute

Ask the patient to choose the statement that best describes her smoking status:

- ☐ A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime.
- ☐ B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.
- ☐ C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
- ☐ D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.
- ☐ E. I smoke regularly now, about the same as BEFORE I found out I was pregnant.

If the patient stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and postpartum.

If the patient is still smoking (D or E), document smoking status in her medical record, and proceed to Advise, Assist, and Arrange.

ADVISE — 1 minute

Provide clear, strong advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus.

ASSESS — 1 minute

Assess the willingness of the patient to attempt to quit within 30 days.

If the patient is willing to quit, proceed to Assist.
If the patient is not ready, provide information to motivate the patient to quit and proceed to Arrange.

ASSIST — 3 minutes +

Suggest and encourage the use of problem-solving methods and skills for smoking cessation (e.g., identify "trigger" situations).

Provide social support as part of the treatment (e.g., "we can help you quit").

Arrange social support in the smoker's environment (e.g., identify "quit buddy" and smoke-free space).

Provide pregnancy-specific, self-help smoking cessation materials.

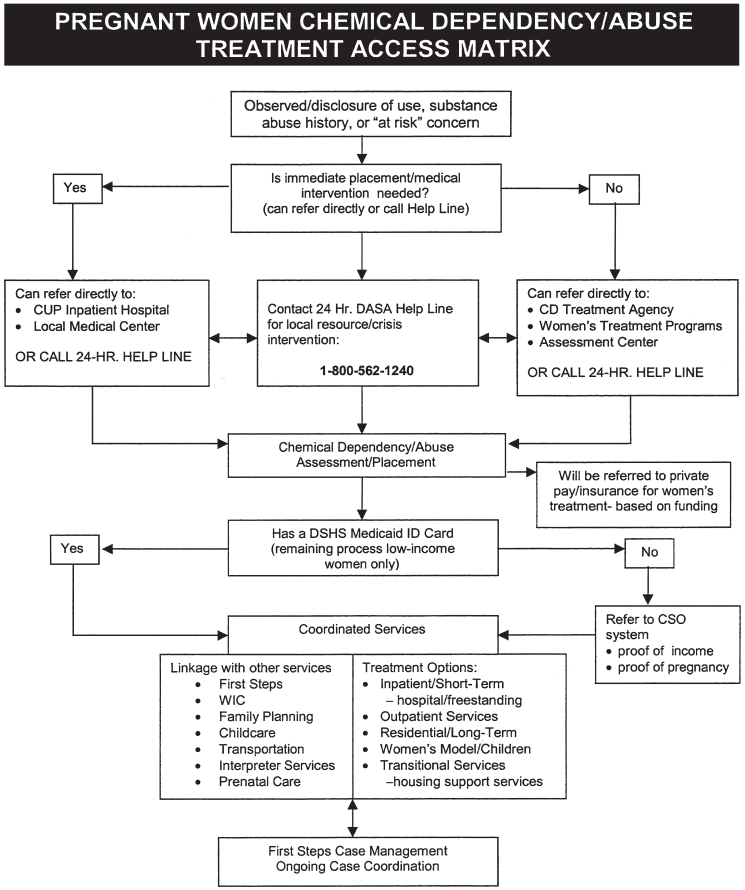
ARRANGE — 1 minute +

Assess smoking status at subsequent prenatal visits and, if patient continues to smoke, encourage cessation.

Data from Melvin C, Dolan Mullen P, Windsor RA, Whiteside HP, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. *Tobacco Control* 2000; 9:1-5.

ACOG Educational Bulletin No. 260, September 2000.

Appendix B: Treatment Access Matrix



Source: DSHS, 2002.

Treatment Access Matrix Key

CD/Women's Treatment Agency: Chemical dependency treatment services certified by DSHS's Division of Alcohol & Substance Abuse (DASA), listed in DASA's service directory with focus on Women's Programs.

Chemical Dependency/Abuse Assessment (Centers): Diagnostic services to determine a person's involvement with alcohol and other drugs and to recommend a course of action.

Childcare: DSHS managed childcare services provided in support of chemical dependency treatment; medical care appointments, foster care, employment, or other approved needs.

Community Service System: Statewide Community Services field offices (CSO) or access points that provide financial, medical and food assistance to eligible clients. Assist with eligibility for Medical ID cards and referrals to other community programs and resources.

Chemically Using Pregnant Women (CUP Program): DSHS inpatient hospital program for acute detox and medical stabilization of pregnant chemical dependent women and their fetus. Provides intensive detox, medical stabilization, and both medical and drug/alcohol treatment services at pre-approved hospitals statewide.

DASA Alcohol/Drug 24-hour Help Line: Confidential 24-hour statewide telephone service to assist with alcohol/drug related crisis intervention, guidance, information and referrals to community resources.

First Steps/Case Management: Community based staff certified by DSHS as a First Steps Provider agency. Pregnant chemically dependent women have higher risk for poor birth outcomes and drug-affected infants. Any history or risk of chemical dependency in the household qualifies eligible pregnant women for services. The focus is on positive birth and parenting outcomes, interventions, linkages and coordination among all providers.

Intensive Inpatient Treatment: Residential inpatient primary alcohol/drug treatment program in a non-medical facility (freestanding) for average of 28 days. Consist of therapy, education, and activities for detoxified alcoholics and addicts, and their families.

Outpatient Services: Individual and group treatment services of varied duration and intensity for chemical dependent patients less than 24 hours a day in a non residential setting.

Residential/Long Term Women's Model: Chemical dependency residential treatment program with personal care services for chronic need of long term services over 90 days. Gender specific women's programs offer the capacity to have children reside with parent, and focus on women's personal issues needed to maintain abstinence, independence, and health.

Adapted from DSHS "Pregnant Women Chemical Dependency/ Abuse Treatment Access Matrix Key" February 2002.

Appendix C: Resources

Statewide Resources

Chemical Dependency Assessment and Treatment

Alcohol/Drug 24-hour Help Line—1-800-562-1240. Provides statewide referral information about treatment, counseling, and support services by county and city for teens and adults. Assistance for providers and clients.

Crisis Line—(206) 722-3700 or 1-800-562-1240 (Alcohol/Drug 24-hour Help Line). Provides statewide confidential assistance for people with alcohol and drug problems, mental health and domestic violence issues; assists with crisis intervention techniques and referral.

Teen Line—24-hours (206) 722-4222 or 1-800-562-1240 (Alcohol/Drug 24-hour Help Line). Assists providers, teens and parents in statewide referrals and information related to chemical dependency, rape and other issues. Volunteer teen counselors M-F, 4-8pm, as available.

Washington State Alcohol Drug Clearinghouse—1-800-662-9111. Provides continually-updated substance abuse resources; information on programs, personnel, referrals and copies of printed materials. Call for a copy of the *Directory of Certified Chemical Dependency Treatment Services in Washington State*.

Alcohol/Drug Help Line Domestic Violence Outreach Project—(206) 722-3700 or 1-800-562-1240 (Alcohol/ Drug 24-hour Help Line). Information about programs in Washington state addressing both domestic violence and chemical dependency.

Washington State Division of Alcohol and Substance Abuse (DASA) Main Line—1-877-307-4557. Information related to DSHS supported alcohol and drug treatment programs.

Regional Perinatal Programs

Northwest Regional Perinatal Program, Seattle
Physician Consultation Line (Medcon)
University of Washington 24-hour medical consultation
Seattle (206) 543-5300
Toll free 1-800-326-5300

Central Washington Regional Perinatal Program, Yakima
Client education and referral (509) 575-8160
Yakima Valley Memorial Hospital Family Birth Place
24-hour medical consultation (509) 575-8233

Inland Northwest Regional Perinatal Center, Spokane
24-hour medical consultation (509) 474-7206
Educational resource (509) 474-7205 or 1-800-442-8533

Southwest Regional Perinatal Program, Tacoma
24-hour Nurse Consultation Line (253) 552-2999
Physician Referral Line (253) 383-3383
Prenatal/childbirth education (253) 403-1036

The Maternal Substance Abuse Screening Initiative for Providers is part of the four Regional Perinatal Programs for the state of Washington.

The four regional perinatal programs:

1. Provide continuing education for health care professionals.
2. Are well established within the state and have taken a leadership role in providing community education.
3. Provide consultation, medical care to high-risk clients, and maternal and neonatal transport from referring hospitals to regional medical centers.
4. Coordinate a statewide program for substance use/abuse training and education.

Contact information for each region coordinator for the Maternal Substance Abuse Screening Initiative

Southwest Washington Regional Perinatal Program
Glenda Shepard RN, BSN, MSA
Tacoma General Hospital
315 Martin Luther King Jr. Way
Tacoma, WA
Phone: (253) 403-1771
Email: glenda.shepard@multicare.org

Northwest Regional Perinatal Program
Sue Kearns, RNC, MN
University of Washington School of Medicine
Dept. of OB-GYN
Box 356460
Seattle, WA 98195-6460
(206) 221-7307
Email: Skearns@u.washington.edu

Inland Northwest Regional Perinatal Center
Gail Peterson, RN
Inland NW Regional Perinatal Center
508 W 6th Avenue #200
Spokane, WA 99204
Phone: (800) 442-8533
Email: petersga@shmc.org

Central Washington Regional Perinatal Program
Susan Johnson, NNP, ARNP
Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
Phone: (509) 575-8160
Email: susan.johnson@yvmh.org

Other Special State-Funded Projects

Comprehensive Program Evaluation Project (CPEP): Safe Babies, Safe Moms

The Maternal-Infant Substance Abuse Intervention Program serves substance abusing pregnant, postpartum, and parenting women (PPW) and their children from birth-to-three at project sites in Snohomish, Whatcom, and Benton-Franklin Counties.

CPEP provides a comprehensive range of services that include chemical dependency treatment, intensive case management services and transitional housing support services. CPEP assists women in accessing needed community resources and transitioning from public assistance to self-sufficiency. CPEP also offers: (1) parenting education; (2) child development activities; and (3) behavioral health related services.

For information at the local level, contact the following:

Snohomish County
TICM (Targeted Intensive Case Management)
Pacific Treatment Alternatives
Contact: Jim Mattson, PhD
(425) 259-7142

PPW Housing Support Services
Catholic Community Services
Contact: Marcia Glendenning
(425) 257-2111

PPW Residential Treatment
Evergreen Manor
Contact: Linda Grant
(425) 258-2407

Whatcom County
TICM (Targeted Intensive Case Management)
Growing Together/Brigid Collins
Contact: Kathryn Jarrett
(360) 734-4616

Benton-Franklin Counties
TICM (Targeted Intensive Case Management)
Benton-Franklin Health District
Contact: Sandy Owen
(509) 943-2614 ext.248

PPW Housing Support Services/
Residential Treatment
Rivercrest
Contact: Margaret Fann
(509) 735-7410

P-CAP

The Parent-Child Assistance Program (P-CAP) provides advocacy services to high-risk substance abusing pregnant and parenting women and their young children in King, Pierce, Spokane, Grant, and Yakima counties. P-CAP services include:

- Referral, support, and advocacy for substance abuse treatment and continuing care for 3 years beginning at enrollment during pregnancy
- Assistance in accessing and using local resources such as family planning, safe housing, health care, domestic violence services, parent skills training, child welfare, childcare, transportation, and legal services
- Linkages to health care and appropriate therapeutic interventions for children
- Regular home visitation and timely advocacy based on client needs

For more information, contact:
University of Washington Fetal Alcohol and Drug Unit:
Therese Grant, PhD, Director, (206) 543-7155.

Other Related Resources for Pregnant Women

Healthy Mothers Healthy Babies—1-800-322-2588
Provides information and referrals for maternity support services, maternity case management, prenatal care, family planning and pediatric care.

Domestic Violence Hotline—1-800-562-6025
24-hour line provides information and referrals.

Tobacco Quit Line—1-877-270-STOP
For assistance quitting tobacco use.

Family Planning TAKE CHARGE Program—
1-800-770-4334
Information and referral resources for family planning.

Websites

The American College of Obstetrics and Gynecologists (ACOG)
www.acog.org

Association of Women's Health Obstetric and Neonatal Nurses (AWHONN)
www.awhonn.org

American College of Nurse Midwives (ACNM)
www.acnm.org

Parent-Child Assistance Program (P-CAP)
www.depts.washington.edu/fadu/

Department of Health (DOH)
www.doh.wa.gov

Substance Abuse Mental Health Services Administration (SAMHSA) National Clearinghouse for Alcohol and Drug Information
www.health.org

Domestic Violence Hotline
www.crisis-support.org

Pediatric Interim Care Center
www.picc.net

TAKE CHARGE
https://wws2.wa.gov/dshs/maa/familyplan/

American Society of Addictions Medicine
www.asam.org

DOH and DSHS
www.didyouask.org

Appendix D: Definitions of Services

Detoxification Services

Assists patients in withdrawing from drugs, including alcohol.

Acute Detox—Medical care and physician supervision for withdrawal from alcohol or other drugs.

Sub-Acute Detox—Non-medical detoxification or patient self-administration of withdrawal medications ordered by a physician and provided in a home-like environment.

Outpatient Treatment Services

Provides chemical dependency treatment to patients less than 24 hours a day.

Intensive Outpatient—A concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families.

Outpatient—Individual and group treatment services of varying duration and intensity according to a prescribed plan.

Outpatient Child Care—A certified outpatient chemical dependency treatment provider may offer on-site child care services approved by the department, offering each child a planned program of activities, a variety of easily accessible, culturally and developmentally appropriate learning and play materials, and promoting a nurturing, respectful, supportive, and responsive environment.

Residential Treatment Services

Intensive Inpatient—A concentrated intervention program including but not limited to individual, group and family therapy, substance abuse education, and development of community support systems and referrals

Recovery House—A program of care and treatment with social, vocational, and recreational activities to aid in patient adjustment to abstinence and to aid in job training, employment, or other types of community activities.

Long-Term—A treatment program with personal care services for individuals with chronic histories of addiction and impaired self-maintenance capabilities. This level of disability requires personalized intervention and support to maintain abstinence and good health.

Appendix E: The Newborn

Newborn Risk Indicators

All infants identified as at-risk by the following indicators should be tested for maternal drugs of abuse **after other identifiable medical causes have been ruled out**:

- Positive maternal toxicology screen
- Jittery with normal glucose level
- Marked irritability
- Inability to sleep/chronic somnolence
- Unexplained seizures or apneic spells
- Microcephaly
- Small for gestational age
- Signs of neonatal abstinence syndrome: marked irritability, high pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, diaphoresis
  Note: Neonatal signs of fetal dependence may be delayed as long as 10-14 days, depending upon the half-life of the substance in question.

Preterm infants are less likely to overtly exhibit at-risk behaviors in spite of substance exposure. Immature organ systems may modify test results.

About Newborn Urine Toxicologies

- Correlation between maternal and newborn test results is poor, depending upon the time interval between maternal use and birth, properties of placental transfer, and time elapsed between birth and neonatal urine collection.
- The earliest urine of the newborn will contain the highest concentration of substances.
- Failure to catch the first urine decreases the likelihood of a positive test.

- Threshold values (the point at which a drug is reported to be present) have not been established for the newborn.
- Fetal effects cannot be prevented by newborn testing.
- Newborn urine reflects exposure during the preceding one to three days.
- Cocaine metabolites may be present for four to five days.
- Marijuana may be detected in newborn urine for weeks, depending on maternal usage.
- Meconium in term infants reflects substance exposure during the second half of gestation; preterm infants may not be good candidates for meconium testing.
- Alcohol is nearly impossible to detect in newborn urine.

When to Perform Newborn Urine Toxicologies

- If results will provide documentation of the client's pattern of drug use, and
- If results will influence management of medical care for the mother and newborn, including treatment options.

Procedure

- Obtain order from baby's provider for urine toxicology testing.
- Explain and document the rationale/need for the test and possible consequences and/or benefits of the test to the mother.
- Perform testing for medical indications, and document results in the patient's medical record.
- Document the discussion with the baby's parent(s).
- Obtain urine drug toxicology from the infant's first void.

- Consent for intrapartum or newborn testing is sought directly or is assumed within the general consent for care (see page 16, "Consent Issues for Testing"). Many hospitals do not seek parental consent for newborn testing, citing its use as a medical diagnostic tool.
- Hospitals and providers should seek consultation from Risk Management staff related to consent.

Management of the Infant with a Positive Urine Toxicology

- Notify infant's provider for diagnostic work-up.
- Anticipate potential range of infant's withdrawal response based on history, assessment, and urine drug testing.
- Use a Neonatal Abstinence Scoring tool as indicated per protocol for narcotic withdrawal.
- Document assessment of family interaction (or lack of interaction) at least each shift. Include positive observations as well as areas of concern.
- Notify social worker or other designated staff member to coordinate comprehensive drug/alcohol assessment and outside referrals, including Child Protective Services. (If designated staff member is not available, reporting to CPS is the responsibility of all health care providers).

Note: CPS may use a patient's chart as documentation in court. A release of information is not required. If the mother is not or has not been motivated to seek treatment, CPS prefers documentation of a positive urine toxicology.

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Community and Family Health
DOH Pub 950-135 5/2002